Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box
Box Number 01

MFDR Date Received
NOVEMBER 17, 2006

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number
M4-07-1807-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was brought by ambulance to Memorial Hermann Hospital and admitted through the ER due to severe injuries from a motorcycle accident…Due to the nature of these severe injuries and complications, the course of treatment was unusually costly and extensive given the uncertainty of the patient's needs and complications from the traumatic injuries. The patient remained hospitalized in rehabilitation for 22 days and he required more surgical intervention. The carrier would only approve 7 days of the hospital stay…The hospital submitted a complete bill on December 19, 2005 for $50,509.25. My client received partial payment totaling $6,090.00 representing 7 days medical care under the per diem guidelines of the ACIHFG…the billed charges exceeded the stop loss threshold for reimbursement at 75% of the billed charges."

Amount in Dispute: $31,791.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

"Total billed charge: $50,509.25

Paid for the first 7 days, 11/22/05 -11/28/05. Denied Room and Board and all charges for dates of service 11/29/05-12/14/05, as not preauthorized. The first 7 days were authorized. We have no record of the provider calling for continued stay review."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 22, 2005 Through December 14, 2005	Inpatient Services	$31,791.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 effective March 14, 2004, 29 TexReg 2360, requires preauthorization and concurrent review for non-emergency inpatient hospital services.
3. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, states inpatient rehabilitation reimbursement shall be at a fair and reasonable rate.
4. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits

   - Z585-The charge for this procedure exceeds fair and reasonable.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
   - X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
   - W1- Workers Compensation State Fee Schedule Adjustment.
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Findings

1. This dispute relates to inpatient rehabilitation services rendered from November 22, 2005 through December 14, 2005 provided in a hospital setting.

   28 Texas Administrative Code §134.401(a)(2), states "Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions."

   The Division finds that the disputed services are applicable to the reimbursement guidelines set out in 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

2. The respondent denied reimbursement for dates of service, November 29, 2005 through December 14, 2005, based upon "X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600", and "X267-According to fee schedule guidelines, certification must be obtained for additional inpatient days beyond those initially precertified. There is no record of additional days being requested/certified, therefore payment is denied; and 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization."

   28 Texas Administrative Code §134.600 (b)(1)(A-C) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care; (c) concurrent review of any health care listed in subsection (i) of this section was approved prior to providing the health care."

   28 Texas Administrative Code §133.1 (a)(7)(A) defines a medical emergency as "a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result

in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part."

The respondent states in the position summary that "Paid for the first 7 days, 11/22/05 -11/28/05. Denied Room and Board and all charges for dates of service 11/29/05-12/14/05, as not preauthorized. The first 7 days were authorized. We have no record of the provider calling for continued stay review."

The requestor counters that "The carrier would only approve 7 days of the hospital stay."

The Division finds that for dates of service November 22, 2005 through December 14, 2005, the medical treatment is not considered a medical emergency because no medical documentation was submitted to support an "emergency" as defined in 28 Texas Administrative Code §133.1 (a)(7)(A); therefore, the disputed services required preauthorization.

3. 28 Texas Administrative Code §134.600 (i)(1) states "The health care requiring concurrent review for an extension for previously approved services includes (1) inpatient length of stay."

   The requestor did not submit documentation to support concurrent review approval was obtained for dates of service November 29, 2005 through December 14, 2005 in accordance with 28 Texas Administrative Code §134.600 (i)(1). Therefore, reimbursement cannot be recommended for these dates.

4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor states in the position summary that "…the billed charges exceeded the stop loss threshold for reimbursement at 75% of the billed charges."
   - The requestor asks reimbursement based upon stop loss which is not applicable to inpatient rehabilitation services per 28 Texas Administrative Code §134.401(a)(2).
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
   - The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		04/04/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.